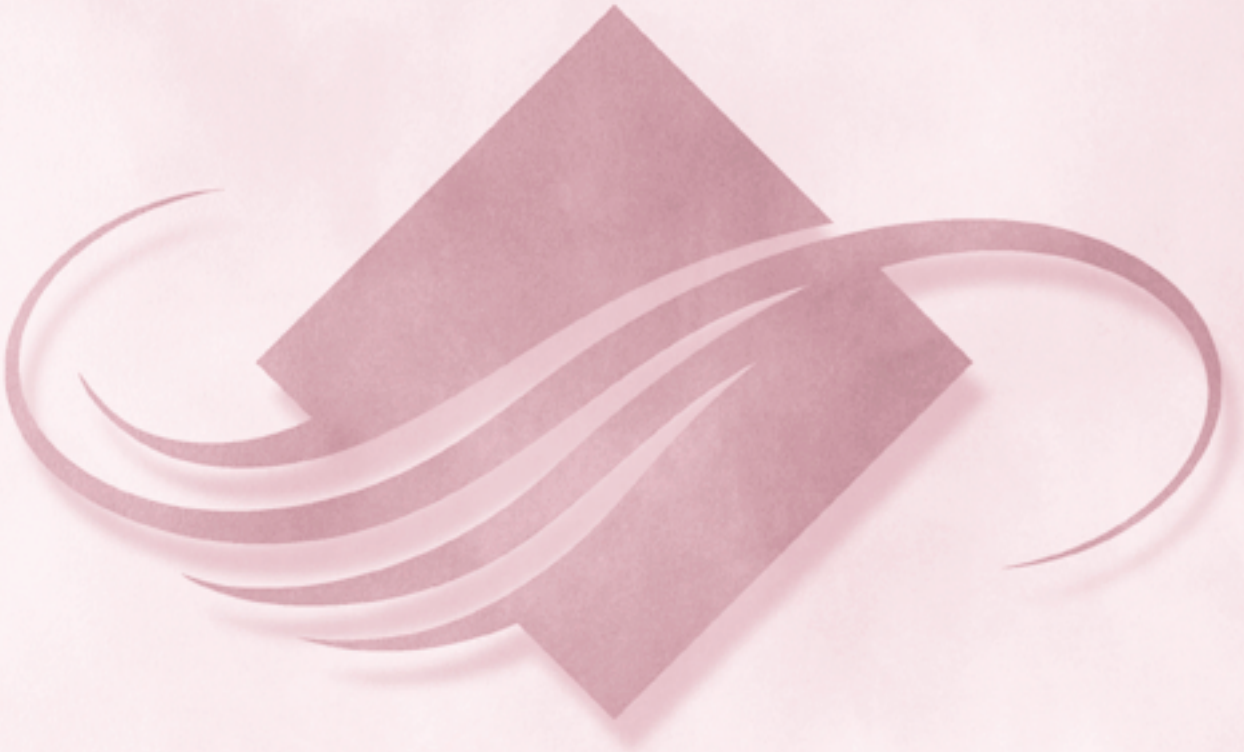
EVIDENCE OF COVERAGE



PERS *Choice*

Supplement to Medicare Plan

Effective

February 1, 2001, through December 31, 2001

Administered by Blue Cross (Blue Cross of California and BC Life & Health Insurance Company) and Merck-Medco Managed Care, L.L.C., for the Board of Administration of the California Public Employees' Retirement System

HOW TO REACH US

CUSTOMER SERVICE

For medical claims status, benefit information, identification cards, booklets, or claim forms, call:

Customer Service Department
Blue Cross of California
1-877-737-7776
1-818-234-5141 (outside the continental U.S.)
1-818-234-3547 (TDD)
Web site: www.bluecrossca.com

MEDICAL CLAIMS AND CORRESPONDENCE

Please mail your medical claims and correspondence to:

PERSCare Health Plan
Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

PRESCRIPTION DRUG PROGRAM

For information regarding the Retail Pharmacy Program or Mail Service Program, call:

Merck-Medco Managed Care, L.L.C.
1-800-316-9178
1-972-915-2800 (outside the continental U.S.)
Web site: www.merck-medco.com

ELIGIBILITY AND ENROLLMENT

For information concerning eligibility and enrollment, contact the Health Benefits Officer at your agency (active) or the CalPERS Health Benefit Services Division (retirees). You also may write:

Health Benefit Services Division
CalPERS
P.O. Box 942714
Sacramento, CA 94229-2714

Or call:

1-800-237-3345
(916) 326-3240 (TDD)

MEDCALL

You can reach a specially trained registered nurse who can address your health care questions by calling MedCall at 1-800-700-9185. Registered nurses are available to answer your medical questions 24 hours a day, seven days a week.

ADDRESS CHANGE

Active Employees: To report an address change, active employees should complete and submit the proper form to their employing agency's personnel office.

Retirees: To report an address change, retirees may either call 1-800-352-2238 or submit a signed written notification, including Social Security number, new address, and other pertinent information, to:

CalPERS Benefit Services Division
P.O. Box 942716
Sacramento, CA 94229-2716

PERSCare MEMBERSHIP DEPARTMENT

For direct payment of premiums, contact:

PERSCare Membership Department
Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386
1-877-737-7776
1-818-234-5141
(outside the continental U.S.)

PERSCare WEB SITE

Visit our Web site at:

www.calpers.ca.gov/perscare

IMPORTANT INFORMATION

No person has the right to receive any benefits of this Plan following termination of coverage, except as specifically provided under the Benefits After Termination or Continuation of Coverage provisions in this booklet.

Benefits of this Plan are available only for services and supplies furnished during the term the Plan is in effect, and while the benefits you are claiming are actually covered by this Plan.

Reimbursement may be limited during the term of this Plan as specifically provided under the terms in this booklet. Benefits may be modified or eliminated upon subsequent years' renewals of this Plan. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the benefits of this Plan.

MedCall

Your Plan includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. When you call MedCall toll free at **1-800-700-9185**, be prepared to provide your name, the patient's name (if you are not calling for yourself), the subscriber's Social Security number, and the patient's phone number.

The nurse will ask you some questions to help determine your health care needs.* Based on the information you provide, the advice may be to:

- Take care of yourself at home. A follow-up phone call may be made to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your physician. If you do not have a physician, the nurse will help you select one by providing a list of physicians who are Preferred Providers in your geographical area.
- Call your physician for further discussion and assessment.
- Immediately call 911.

In addition to providing a nurse to help you make decisions about your health care, MedCall gives you free unlimited access to its Audio Health Library, featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll free 1-800-700-9185 and follow the instructions given.

* Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your physician's care.

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BENEFIT AND ADMINISTRATIVE CHANGES

Notice

Terms and conditions contained in this Evidence of Coverage apply to an 11-month contract period ("plan year") effective February 1, 2001, through December 31, 2001. Please read this booklet carefully.

The following is a brief summary of benefit and administrative changes that will take effect February 1, 2001.

1. ***Claim-Free* Service.** Members residing outside California may now enroll in the *Claim-Free* program (see page 5).
2. **Vision Care Benefits.** The vision care examination and lens maximums will apply on a plan year basis, in effect from February 1, 2001, through December 31, 2001. New language describes covered vision care benefits for Members residing inside and outside California, including how to obtain reimbursement for services and supplies (see page 8).
3. **Outpatient Prescription Drug Program:**

   - **Incentive Formulary.** The list of formulary medications has not changed. However, the Plan has moved to an incentive-based program, where higher copayments will apply to certain covered drug categories.
   - **Prescriptions Drug Copayments.**

     Retail Program:

Generic	$5
Formulary brand-name	$15
Non-formulary brand-name	$30

     Mail Service Program:

Generic	$10
Formulary brand-name	$25
Non-formulary brand-name	$45

   - **Managed Rx Coverage Program.** Language has been added to describe Merck-Medco's Managed Rx Coverage Program (see page 15).
   - **Managed Prior Authorization Program.** The list of prescription drugs that require prior authorization by Merck-Medco Managed Care, L.L.C., has been updated (see page 16).
   - **Mail Service Program.** A one thousand dollar ($1,000) maximum plan year copayment (per person) now applies for mail order prescriptions.
   - **Injectable Contraceptives.** Injectable contraceptives (e.g., Depo-Provera) are now covered.

PERS Choice SUPPLEMENT TO MEDICARE PLAN - SUMMARY OF BENEFITS

This is only a summary of Plan benefits. See page 11 for a detailed description of how Supplement to Medicare Benefits are paid by the PERS Choice Plan. Please review this booklet and *Medicare & You* (the handbook describing Medicare benefits) for specific information on benefits and exclusions.

Benefit Category	Medicare Pays	Member Pays*
Hospital		
Inpatient and Outpatient	See Medicare Handbook	No charge — If Medicare-approved.
Physician/Preventive Care		
Office/Home/Hospital Visits	See Medicare Handbook	No charge — If Medicare-approved.
Gynecological Exam (Pap test)	See Medicare Handbook	No charge — If Medicare-approved.
Allergy Testing/Treatment	See Medicare Handbook	No charge — If Medicare-approved.
Hearing Aid Services	See Medicare Handbook	20% of Blue Cross' Allowable Amount (see page 13).
Diagnostic X-Ray/Laboratory	See Medicare Handbook	No charge — If Medicare-approved.
Ambulance	See Medicare Handbook	No charge — If Medicare-approved.
Emergency Care/Services Under certain conditions, Medicare helps pay for emergency outpatient care received from non-participating hospitals.	See Medicare Handbook	No charge — If Medicare-approved.
Mental Health		
Inpatient	See Medicare Handbook	No charge — If Medicare-approved.
Outpatient	See Medicare Handbook	No charge — If Medicare-approved. (Medicare pays 50% of the approved amount for most services.)
Home Health Services Medically necessary services obtained through a licensed home health agency.	See Medicare Handbook	No charge — If Medicare-approved.
Skilled Nursing Care Up to 100 days each benefit period in a Medicare-approved facility.	See Medicare Handbook	No charge — If Medicare-approved.
Speech/Physical/ Occupational Therapy		
Speech	See Medicare Handbook	No charge — If Medicare-approved.
Physical	See Medicare Handbook	No charge — If Medicare-approved.
Occupational	See Medicare Handbook	No charge — If Medicare-approved.

***Important Note:** The term "No charge" above applies when benefits are payable by Medicare and you use a provider who accepts Medicare assignment (i.e. covered services will be paid in full). However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by PERS Choice and Medicare. See page 11 for important information regarding Plan payments.

Benefit Category	Medicare Pays	Member Pays*
Chiropractic Manual manipulation of the spine furnished by a licensed chiropractor to correct a subluxation that can be demonstrated by an X-ray.	See Medicare Handbook	No charge — If Medicare-approved.
Durable Medical Equipment	See Medicare Handbook	No charge — If Medicare-approved.
Other		
Heart Transplants	See Medicare Handbook	No charge — If Medicare-approved.
Kidney Dialysis and Transplants	See Medicare Handbook	No charge — If Medicare-approved.
Hospice Care	See Medicare Handbook	No charge — If Medicare-approved.
Podiatrists' Services	See Medicare Handbook	No charge — If Medicare-approved.
Christian Science Treatment	See Medicare Handbook	No charge — If Medicare-approved.
Blood — All but the first three pints per calendar year	See Medicare Handbook	No charge — If Medicare-approved.
Prescription Drugs Retail Pharmacy Program (PAID Prescriptions)	Not Covered by Medicare	$5 generic $15 formulary brand-name drug $30 non-formulary brand-name drug Up to a 30-day supply.
Mail Service Program (Merck-Medco Rx Services)		$10 generic $25 formulary brand-name drug $45 non-formulary brand-name drug Up to a 90-day supply. A $1,000 maximum copayment per person per plan year applies.
Vision Care One exam and two lenses per plan year. One set of frames during a 24-month period. **Maximum Allowance** Exam ..... $35 Frames..... $30 Each lens: Single Vision..... $20 Bifocal..... $35 Trifocal..... $45 Lenticular..... $50 Contact Lenses..... $100	Not Covered by Medicare	Any amount in excess of the Maximum Allowance

***Important Note:** The term "No charge" above applies when benefits are payable by Medicare and you use a provider who accepts Medicare assignment (i.e. covered services will be paid in full). However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by PERS Choice and Medicare. See page 11 for important information regarding Plan payments.

HOW TO USE THE PLAN

Welcome to PERS Choice!

This Supplement to Medicare Plan is designed for Members enrolled in the California Public Employees' Retirement System's (CalPERS) health benefits program who are also enrolled in both Parts A (hospital insurance) and B (medical insurance) of Medicare. After you or your eligible family members are enrolled in this Plan, you may not change enrollment to a Basic Plan unless (1) such change may be permitted in a subsequent open enrollment period, or (2) there is an involuntary termination of your Medicare benefits, or (3) you move, other than temporarily, outside the United States as defined in the Federal Social Security Act. If you voluntarily cancel Part B of Medicare, you will not be eligible for a Basic Plan, nor will you be allowed to remain in this Plan.

A family group member, including a person enrolled in this Plan, who is not eligible for or not enrolled in Medicare and continues in the PERS Choice Basic Plan may enroll in this Plan when he or she attains eligibility by enrollment in Medicare.

Please note that this Plan does not cover custodial care in any facility or situation, including a skilled nursing facility.

As a PERS Choice Member, you are responsible for meeting the requirements of the Plan. Lack of knowledge of, or lack of familiarity with, the information contained in this booklet does not serve as an excuse for noncompliance. So please take some time to become familiar with this booklet and *Medicare & You*.

Thank you for joining PERS Choice.

Medicare & You

Each year the U.S. Department of Health and Human Services publishes a Medicare handbook entitled *Medicare & You*. This handbook outlines the benefits Medicare provides and includes any changes in deductibles, coinsurance, or benefits that may occur from year to year. To obtain a copy, contact your nearest Social Security office, or write to:

Medicare Publications
Department of Health and Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

A directory of physicians who accept Medicare assignment (Medicare Provider Directory) can also be obtained from the Department of Health and Human Services at the above address.

Always make sure the individuals or organizations providing services to you are approved to provide Medicare services. Please ask if you are not sure.

PERS Choice Identification Card

As a PERS Choice Member, you will receive a PERS Choice ID card. Simply present this card to receive medical services and prescription drug benefits of the Plan. If you need a replacement card, call the Blue Cross Customer Service Department at 1-877-737-7776.

Possession of a PERS Choice ID card confers no right to services or benefits of this Plan. To be entitled to services or benefits, the holder of the card must in fact be a Plan Member on whose behalf premiums have actually been paid.

If you allow the use of your ID card (whether intentionally or negligently) by an unauthorized individual, you will be responsible for all charges incurred for services received. Any other person receiving services or other benefits to which he or she is not entitled, without your consent or knowledge, is responsible for all charges incurred for such services or benefits.

Members Who Move Outside the United States

If you move, other than temporarily, outside the United States as defined in the Federal Social Security Act, you are no longer eligible for this Plan. You must change enrollment to a Basic Plan as Medicare does not provide benefits when you are permanently outside the United States. Please contact the Health Benefits Officer at your agency (active) or the CalPERS Health Benefit Services Division (retirees) as soon as possible to enroll in a Basic Plan.

Claim-Free Service

As a PERS Choice Supplement to Medicare Plan Member, you may enroll in a claims filing program called the *Claim-Free* program. Your enrollment in the *Claim-Free* program means that you need not file a paper claim yourself for Supplement to Medicare professional and hospital benefits as long as your provider billed Medicare directly.

NOTE: The *Claim-Free* program does not apply to the "Benefits Beyond Medicare" listed on page 12. See page 7 for more information on how to obtain reimbursement for those benefits.

Once enrolled in the *Claim-Free* program, your Supplement to Medicare benefits will automatically be paid through Blue Cross of California's *Claim-Free* process, which makes it possible for Blue Cross plans to electronically obtain Medicare claims data directly from Medicare claims processors. In some cases, you may receive your PERS Choice Supplement to Medicare benefit claim payment faster than your Medicare payment.

To enroll in the *Claim-Free* program, return the postcard that will be sent to you automatically once you are enrolled in the PERS Choice Supplement to Medicare plan. You may also call Blue Cross at 1-877-737-7776 to enroll. Please make sure you have your Medicare card available when you place the call.

You may disenroll from the *Claim-Free* program for any reason by calling Blue Cross of California at 1-877-737-7776. Make sure you have your Medicare card available when you place the call. If you choose to disenroll in the Claim-Free program, you will need to submit your claims to Medicare as discussed below.

Supplement to Medicare Benefits

Hospital Benefits (Part A)

If you are not enrolled in the *Claim-Free* program, you should present your PERS Choice ID card along with your Social Security Medicare ID card at the hospital admissions desk. The hospital may bill Blue Cross of California for benefits under your PERS Choice Supplement to Medicare Plan after they have received payment from Medicare. You should discuss billing procedures with the hospital's billing office.

If you do not have your PERS Choice ID card when you enter the hospital or if the status of your contract is questioned, ask the hospital to contact Blue Cross of California at 1-877-737-7776.

Medical Benefits (Part B)

If you are not enrolled in the *Claim-Free* program, you must first submit all medical claims to Medicare.

After Medicare has processed your claim, you will receive a Medicare Summary Notice statement. Write your member number and group number (from your PERS Choice ID card) on the Medicare Summary Notice statement, then mail it and a copy of the itemized bill for the services received to:

Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

Blue Cross of California will make supplemental payments as described under Description of Benefits beginning on page 11.

Payments for services covered by this Plan may be paid to you or directly to the provider if he or she is a Physician Member.

Outside the United States

Medicare does not provide benefits when you are outside the United States or its territories and need medical attention or hospitalization for illness or injury. Therefore, you should pay the bill yourself and submit a copy of the bill along with a report from the attending physician to Blue Cross. You will then be reimbursed for covered services by Blue Cross.

All claims should be submitted to:

Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

Please refer to page 14 for information regarding the benefits which will be provided along with information regarding exceptions that may apply to Canadian or Mexican hospitals.

For Prescription Drug Claims: There are no participating pharmacies outside of the United States. To receive reimbursement for outpatient prescription drugs purchased outside the United States, complete a Direct Reimbursement Claim form and mail it to PAID Prescriptions, L.L.C., at P.O. Box 1030, Parsippany, NJ 07054-1030 (or mail it to the address listed on the back of the claim form). Prescription medication covered by the Plan will be reimbursed at one hundred percent (100%), minus a thirty dollar ($30) copayment for a 1-month supply, based on the foreign exchange rate on the date the claim is processed. **Claims must be submitted within twelve (12) months from the date of service.**

Benefits Beyond Medicare

To obtain reimbursement for those services and supplies that are a benefit of your "Benefits Beyond Medicare" coverage, submit copies of your bills, properly identified, to:

Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

No claim forms are necessary.

Bills submitted should include:

The statement "Benefits Beyond Medicare"	The Medicare ID number & the Medicare effective date
Subscriber's name	Date(s) of service
Subscriber ID / Member number	Diagnosis
Group number	Type(s) of service
Patient's name	Provider's name & tax ID number
Patient's date of birth	Amount charged for each service
Patient's date of injury/illness	Patient's other insurance information

Claims for benefits provided under "Benefits Beyond Medicare" must be submitted within fifteen (15) months after the date services were provided.

To receive reimbursement for **Vision Care Benefits,** refer to the following page for the mailing address and other information.

Claims Review for Benefits Beyond Medicare

PERS Choice reserves the right to review all claims and medical records to determine whether any exclusions or limitations apply.

Vision Care Benefits

For California Residents

If you are a California resident, your routine vision care benefits are administered by Vision Service Plan (VSP). To receive maximum benefits under this Plan, make sure your vision care provider is a VSP participating provider. VSP providers have agreed to discounted fee arrangements which should reduce your out-of-pocket expenses. VSP participating providers will obtain an authorization number on your behalf and will submit claims to VSP after you have received services.

To locate a VSP participating provider near you, call VSP at 1-800-877-7195 or visit the Web site at www.vsp.com.

You are not restricted to using VSP providers. If you choose to receive services from a non-participating provider, you must pay the bill at the time you receive the services and then request reimbursement from VSP.

To obtain reimbursement directly from VSP, submit a copy of an itemized bill, listing the covered services and supplies you received, to:

VSP
Non-Member Doctor Claims
P.O. Box 997100
Sacramento, CA 95899-7100

For Members Residing Outside California

If you reside outside the state of California, vision care benefits will be provided as shown on page 12 for covered services and supplies received from any qualified vision care provider.

To obtain reimbursement for those services and supplies, submit copies of your itemized bills, properly identified, to:

Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

Routine Vision Care Benefits - What Is Covered

The Vision Care Benefits described on page 12 are provided for *routine* vision care ONLY. Examples of covered services include *routine* eye examinations, refractions, pupil dilation, glasses and contact lenses. Examples of vision care services that are **not** considered *routine* include examinations for diagnosed medical conditions of the eye such as cataracts or glaucoma, and eyeglasses or contact lenses prescribed following cataract surgery.

To obtain reimbursement for the treatment of such non-routine medical conditions of the eye, you must first submit copies of your bills to Medicare for processing. After Medicare has paid its portion of the bill, submit a copy of the bill along with a copy of your Medicare Summary Notice to:

Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

HOW TO USE THE PLAN

Request for Additional Information

A questionnaire will be sent to you annually regarding other health care coverage or Medicare coverage. A questionnaire regarding third-party liability will be sent to you following Blue Cross' receipt of any claim which appears to be the liability or legal responsibility of a third party. Your cooperation in returning the form promptly will provide Blue Cross with information necessary to process your claim. If another carrier has the primary responsibility for claims payment, submit a copy of the other carrier's Explanation of Benefits with the itemized bill from the provider of service. Blue Cross cannot process your claim without this information.

Payment to Providers—Assignment of Benefits

The benefits of this Plan will be paid directly to Preferred Providers and medical transportation providers. Also, Non-Preferred Providers and other providers of service will be paid directly when you assign benefits in writing.

LIFETIME MAXIMUM BENEFIT

The lifetime maximum benefit payable for all covered services provided under this Plan is two million dollars ($2,000,000) per person. Benefits in excess of this amount will not be provided to you or to your providers.

DESCRIPTION OF BENEFITS

Supplement to Medicare Benefits

Subject to benefits being covered by Medicare while you are enrolled under PERS Choice, PERS Choice will pay the amounts shown below under *Plan Payments* for medically necessary services and supplies furnished for the diagnosis or treatment of illness, pregnancy, or accidental injury. The date on which a service or supply is furnished will be deemed the date on which the expense was incurred or the charge made. (For information on Medicare benefits, please refer to the *Medicare & You* handbook or call your nearest Social Security office.)

Payment of Supplement to Medicare Benefits

Deductibles

When a Member is receiving concurrent benefits from Medicare, PERS Choice pays one hundred percent (100%) of the Medicare Part A and B deductibles.

Plan Payments

When a Member is receiving concurrent benefits from Medicare, PERS Choice payments for covered charges are provided according to whether the provider accepts Medicare assignment. The following illustrates how PERS Choice payments will be determined.

If the provider ***accepts Medicare*** *Assignment:*	*If the provider* ***DOES NOT accept Medicare*** *Assignment:*
The PERS Choice payment is limited to one hundred percent (100%) of the difference between the amount paid by Medicare and Medicare's approved amount. See notes 1 and 2 below.	The PERS Choice payment is limited to one hundred percent (100%) of the Medicare Limiting Amount (defined on page 40), less the amount paid by Medicare for covered charges. See notes 1 and 3 below.

NOTES:

1. The PERS Choice payment plus the Medicare payment will be accepted as payment in full by Blue Cross Physician Members whether they accept Medicare assignment or not.
2. The PERS Choice payment plus the Medicare payment will be accepted as payment in full by providers who are not Blue Cross Physician Members but who **DO** accept Medicare assignment.
3. Plan Members will be responsible for the difference between the amount paid by PERS Choice and Medicare and the charges billed by providers who are not Blue Cross Physician Members and who do not accept Medicare assignment, within the limits of applicable law.

DESCRIPTION OF BENEFITS

Benefits Beyond Medicare

PERS Choice will provide the following coverage for medically necessary services and supplies which are not covered by Medicare:

- **Vision Care Benefits** (see below).
- **Hearing Aid Services** (see page 13).
- **Outpatient Prescription Drug Benefits** (see pages 17 through 20).

Vision Care Benefits

PERS Choice provides benefits for routine vision care services and supplies up to the maximum allowance shown below:

	Allowance
Complete eye examination	$35.00
Lens (each):	
Single vision	$20.00
Bifocal	$35.00
Trifocal	$45.00
Lenticular	$50.00
Contact lenses (see below)	$100.00
Frames	$30.00

Examinations are limited to one (1) per Plan Member and lenses are limited to two (2) per Plan Member during a plan year. Frames are limited to one (1) set per Plan Member over a two-year period.

Once each plan year, you may have an eye examination for refractive error, including refraction, examination of the inner eye, measurement of eye tension, routine testing for visual field, and muscle balance. If normal examination reveals the need, a complete visual field examination, including pupil dilation or muscle balance, will be allowed. A follow-up visit for muscle balance will also be covered if medically necessary.

When an eye examination indicates that correction is necessary for proper visual health and welfare, PERS Choice will pay up to the maximums stated for covered supplies.

Contact Lenses

When the Plan Member chooses contact lenses instead of other eyewear, PERS Choice provides payment only up to the combined allowance for frames and lenses specified above**, but not to exceed one hundred dollars ($100.00).**

PERS Choice will also pay a maximum of one hundred dollars ($100.00) toward the purchase of contact lenses when medically necessary following cataract surgery, or if they are the only means by which vision in the better eye can be corrected to at least 20/70.

Vision Care Benefit Exclusions

The following are excluded under the Plan:

1. Lenses that do not require a prescription or sunglasses, plain or prescription. Glasses with a tint other than No. 1 or No. 2 will be considered sunglasses for the purpose of this exclusion.

2. Services and materials (a) in connection with non-surgical treatment or procedures, such as orthoptics and visual training; (b) received in a United States government hospital, furnished elsewhere by or for the United States government, or provided by any government plan or law under which the individual is or could be covered; or (c) provided under workers' compensation benefits.

3. Replacement of lenses or frames which were furnished under PERS Choice and which have been lost, stolen or broken.

4. Any procedure done to correct a refractive error, including surgeries such as radial keratotomy, optical keratoplasty, or myoptic keratomileusis.

Hearing Aid Services

PERS Choice provides benefits for covered hearing aid services and supplies at eighty percent (80%) of Blue Cross' Allowable Amount.

Hearing aid services include an audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

The hearing aid (monaural or binaural), including ear mold(s), the hearing aid instrument, initial battery cords, and other ancillary equipment, is subject to a maximum payment of one thousand dollars ($1,000) per Member once every thirty-six (36) months. The Plan provides payment of up to one thousand dollars ($1,000) regardless of the number of hearing aids purchased. This benefit also includes visits for fitting, counseling, adjustment, and repairs at no charge for a one-year period following the provision of a covered hearing aid.

Hearing Aid Benefit Exclusions

The following are excluded under the Plan:

1. Purchase of hearing aid batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.

2. Charges for a hearing aid which exceeds specifications prescribed for correction of hearing loss.

3. Replacement parts for hearing aids or repair of hearing aids after the covered one-year warranty period.

4. Replacement of a hearing aid more than once in any period of thirty-six (36) months.

5. Surgically implanted hearing devices.

Temporary Absence Outside the United States

When covered charges are incurred during the first six (6) months of a temporary absence outside the United States and its territories (unless provided in Canada or Mexico*), PERS Choice will provide the benefits as described in the PERS Choice Basic Plan Evidence of Coverage booklet as though the Member incurring such charges were insured under that Plan. However, if a Member is hospital-confined on the last day of the six (6) months' temporary absence outside the United States, benefits will be provided for the duration of the confinement or until the maximum benefits have been provided.

*Exception for Canadian and Mexican Hospitals. Medicare generally cannot pay for hospital or medical services outside the United States. But it can help pay for care in qualified Canadian or Mexican hospitals in three situations: (1) if you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital that can provide the care you need; (2) if you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists; or (3) if you are in Canada traveling by the most direct route to or from Alaska and another state and an emergency occurs which requires that you be admitted to a Canadian hospital (this provision does not apply if you are vacationing in Canada).

When Medicare hospital insurance (Part A) covers your inpatient stay in a Canadian or Mexican hospital, your PERS Choice medical insurance can cover necessary physician services and any required use of an ambulance.

MANAGED Rx COVERAGE™ PROGRAM

As part of the Plan's drug program, Merck-Medco provides Managed Rx Coverage (MRxC) utilization management services. The purpose of the MRxC program is to establish appropriate threshold levels for specific drug therapy categories and to review patient cases exceeding these thresholds with providers. The MRxC program relies on clinically-based dosing and/or duration recommendations to set appropriate drug threshold limits. Within each therapy management category, clinical criteria or rules are applied to establish the thresholds at which a prescription will be rejected at the "Point-of-Sale."

The MRxC program provides a mechanism by which you or your physician may request a review of your prescription for authorization of coverage. The mechanism, or Point-of-Sale message, notifies the pharmacist with a message **"Plan Limits Exceeded"** or **"Prior Authorization Required"** along with an 800 number. The pharmacist can use this 800 number to initiate the review process. This process is usually completed within twenty-four (24) hours. You will receive written notification of approval or denial.

If, upon review, utilization is found to be within the scope of the benefit, coverage is provided. When approved, the prescription can be filled immediately by any retail Participating Pharmacy (PAID) or through the mail service (Merck-Medco Rx Services). If, upon review, coverage cannot be provided, MRxC provides a mechanism for an appeal of the coverage decision by your physician. Just have your physician contact Merck-Medco for an appeals review. If the prescription quantity request is denied, charges for administering the drug in excess of the approved amount will not be covered.

Drug therapies subject to review through the Managed Rx Coverage Program include the following categories (a few examples are shown in parenthesis):

Antidepressant Therapy (Wellbutrin SR only)

Antiemetic Therapy Management (Kytril, Zofran)

Anti-Influenza Therapy (Relenza, Tamiflu)

Anti-Secretory Therapy (Prilosec, Zantac)

COX-2 Inhibitor Therapy (Celebrex, Vioxx)

Erectile Dysfunction Therapy* (Muse, Viagra)

Migraine Therapy Management (Imitrex, Zomig)

NSAID Therapy* (Toradol only)

Onychomychosis (Lamisil, Sporanox)

Paget's Disease Management* (Actonel)

Pain Therapy Management (Stadol NS)

Vaginitis Therapy* (Diflucan 150mg.)

*No Coverage Review on these products.

Drugs in the above categories will be identified to the dispensing pharmacist by the message **"Plan Limits Exceeded"** or **"Prior Authorization Required"** depending on the drug or drug category. Other drug or drug categories may be added to the list at the discretion of the PERS Choice Plan.

MANAGED PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

As part of the Plan's drug program, Merck-Medco provides Managed Prior Authorization services. The purpose of Prior Authorization is to ensure that certain drugs, including but not limited to those listed below, are used according to specific criteria determining medical appropriateness and cost-effectiveness. These drugs require Prior Authorization before payment can be approved.

Drugs Purchased Through the Retail Pharmacy Program (PAID Prescriptions)

When a prescription requires Prior Authorization, the pharmacy is notified before the drug is dispensed. Your physician is then contacted by a Merck-Medco Managed Care, L.L.C., pharmacist to verify that the prescribed medication meets the Plan's approved guidelines. This process is usually completed within twenty-four (24) hours. You will receive written notification of approval or denial. When approved, the prescription can be filled immediately by any retail Participating Pharmacy (PAID) or through mail service (Merck-Medco Rx Services). If necessary, the prescription can be refilled until the Prior Authorization termination date disclosed in the letter of approval. You must then have the authorization renewed if the prescription is to continue. If Prior Authorization is denied, you will be notified in writing.

Drugs Requiring Prior Authorization

Prior Authorization is required for brand-name drugs and their generic equivalents in the following drug categories (a few examples are shown in parenthesis):

Acne Therapy (Accutane, Retin-A)

Amphetamines (Adderall, Desoxyn)

CNS Stimulants (Ritalin, Cylert)

Erythroid Stimulants (Epogen/Procrit)

Fertility Drugs (Clomid, Lupron) Note: Drugs for the treatment of infertility are not covered

Growth Hormones (Nutropin, Protropin)

Immune globulins (Gammar, Gammagard)

Interferons (Betaseron, Infergen)

Miscellaneous Biotechnology Agents (Copaxone)

Myeloid Stimulants (Leukine/Neupogen)

Rheumatoid Arthritis Agents (Enbrel)

Drugs in the above categories will be identified to the dispensing pharmacist by the message "**Prior Authorization Required.**" Other drugs may be added to the list at the discretion of the PERS Choice Plan.

For more information regarding Managed Prior Authorization, call 1-800-316-9178 or write to:

Merck-Medco Managed Care, L.L.C.
100 Parsons Pond Rd.
Franklin Lakes, NJ 07054

OUTPATIENT PRESCRIPTION DRUG PROGRAM

The Outpatient Prescription Drug Program is administered by Merck-Medco Managed Care, L.L.C., through its subsidiaries PAID Prescriptions, L.L.C., and Merck-Medco Rx Services. This program will pay for prescription drugs that are (a) prescribed in connection with a covered illness or accidental injury; (b) dispensed by a registered pharmacist, subject to the exclusions listed on pages 21 and 22; (c) approved through the Managed Rx Coverage Program described on page 15; and (d) approved through the Managed Prior Authorization Program as described on page 16.

The Plan's drug program is designed to save you money by encouraging you to ask your physician to prescribe generic drugs whenever possible and to prescribe drugs under Merck-Medco's Preferred Prescriptions Incentive Formulary. In an incentive-based formulary arrangement, the same list of formulary medications remains in place; however, a higher copayment is charged for non-formulary medications. Patients can still receive any covered drug and your physician still maintains the choice of drug prescribed. This incentive formulary, available through the Retail Pharmacy Program and the Mail Service Program, provides maximum savings to the Plan without compromising safety and efficacy standards. A listing of the drug formulary can be obtained by calling Merck-Medco Member Services at 1-800-316-9178, or by visiting the Web site at www.merckmedco.com.

Your copayment will vary based on which program you use, whether you use generic or brand-name drugs, and whether your brand-name drug is on the Preferred Prescriptions Formulary. To find out if your medication is on the Preferred Prescriptions Formulary, call Merck-Medco Member Services at 1-800-316-9178, or visit the Web site at www.merckmedco.com.

Retail Pharmacy Program (PAID Prescriptions, L.L.C.)

Medication for a short duration, up to a thirty (30) day supply, may be obtained from a Participating Pharmacy by using your PERS Choice ID card.

While this program was designed primarily for use in California, there are many Participating Pharmacies outside California that will also accept your PERS Choice ID card. At Participating Pharmacies, simply show your ID card and pay either a five dollar ($5.00) copayment for generic drugs, a fifteen dollar ($15) copayment for formulary brand-name drugs, or a thirty dollar ($30) copayment if your brand-name drug is not on the Preferred Prescriptions Formulary. If the pharmacy does not accept your ID card, please follow the procedure for using a non-Participating Pharmacy (see page 18).

Mail Service Program (Merck-Medco Rx Services)

Maintenance medication for ongoing or chronic conditions may be obtained by mail, for up to a ninety (90) day supply, through Merck-Medco Rx Services.

Mail service offers additional savings and convenience if you need prescription medication on an ongoing basis. For example:

- **Additional Savings**: You can receive up to a ninety (90) day supply of medication for only ten dollars ($10.00) for each generic drug, twenty-five dollars ($25.00) for each formulary brand-name drug, or forty-five dollars ($45.00) for each non-formulary brand-name drug. In addition to saving two copayments, you save additional trips to the pharmacy.
- **Convenience:** Your medication is delivered to your home.
- **Security:** You can receive larger quantities of medication at one time.
- **A toll-free customer service number:** Your questions can be answered by calling a Merck-Medco Rx Services representative or pharmacist at 1-800-316-9178.
- **Out-of-pocket maximum**: Your maximum plan year copayment (per person) is one thousand dollars ($1,000).

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Copayment Structure

The following table shows the copayment structure for the retail pharmacy and mail service programs:

Retail Pharmacy	
Generic	**$5.00** per prescription
Formulary Brand	**$15.00** per prescription
Non-Formulary Brand	**$30.00** per prescription 30-day supply
Mail Service	
Generic	**$10.00** per prescription
Formulary Brand	**$25.00** per prescription
Non-Formulary Brand	**$45.00** per prescription 90-day supply

The copayment applies to each prescription order and to each refill. The copayment is not reimbursable and cannot be used to satisfy any deductible requirement.

All prescriptions filled by mail service will be filled with an FDA-approved bioequivalent generic substitute if one exists, unless the physician specifies otherwise.

A one thousand dollar ($1,000) maximum plan year copayment (per person) applies to mail order prescriptions.

How to Use the Retail Pharmacy Program
(Both In-State and Out-of-State Pharmacies)

Participating Pharmacy

1. Take your prescription to any Participating Pharmacy. To locate a Participating Pharmacy near you, call Merck-Medco Member Services at 1-800-316-9178, or visit the Web site at www.merckmedco.com.
2. Present your PERS Choice ID card to the pharmacist.
3. The pharmacist will fill the prescription for up to a thirty (30) day supply of medication.
4. You will be required to sign a receipt for the prescription and pay the pharmacist your appropriate copayment for each prescription order or refill.

NOTE: Submit a Direct Reimbursement Claim form available from PAID Prescriptions if you pay a Participating Pharmacy the full cost of your medication at the time of purchase without presenting your ID card. Your reimbursement will be the same as if you had used a non-Participating Pharmacy (see the example on page 19).

Non-Participating Pharmacy

If you purchase drugs at a non-Participating Pharmacy, either inside or outside California, you will be required to pay the full cost of the medication at the time of purchase. To receive reimbursement, complete a Direct Reimbursement Claim form and mail it to the address indicated on the form. **Claims must be submitted within twelve (12) months from the date of purchase**.

Payment will be made directly to you. It will be based on the amount covered for a Participating Pharmacy minus the appropriate copayment (five dollars [$5.00] for each generic drug, fifteen dollars [$15.00] for each formulary brand-name drug, and thirty dollars [$30.00] for each non-formulary brand-name drug).

Example of Direct Reimbursement Claim for a Formulary Brand-Name Drug

1. Pharmacy charge to you (Retail Charge) $38.00
2. Participating Pharmacy covered charge (PAID's Allowable Amount) $20.00
3. Amount in excess of PAID's Allowable Amount..... $18.00
4. Your copayment (Formulary Brand-Name)..... $15.00
5. Your out-of-pocket cost (Line 3 plus line 4)..... $33.00
6. Your reimbursement (Line 1 minus line 5) ..... $ 5.00

As you can see, using non-Participating Pharmacies, or not using your ID card at a Participating Pharmacy, may result in substantial cost to you. Under certain circumstances, PAID's Allowable Amount may be below your copayment amount and no reimbursement would be allowed.

NOTE: Covered drugs purchased from your physician will be reimbursed under the non-Participating Pharmacy benefit through PAID Prescriptions.

Direct Reimbursement Claim Forms

Direct Reimbursement Claim forms and information on Participating Pharmacies outside California are available from:

PAID Prescriptions, L.L.C.
399 Jefferson Road
Parsippany, NJ 07054
Attention: Member Services
1-800-316-9178
www.merckmedco.com

How to Use the Mail Service Program

If you must take medication on an ongoing basis, the Mail Service Program is ideal for you. To use this program, just follow these steps:

1. Ask your physician to prescribe needed medications for up to a ninety (90) day supply, plus refills if appropriate.

2. Send the following to Merck-Medco Rx Services in the postage-paid, pre-addressed envelope:

   a. the original prescription order(s) your physician gives you.

b. the completed Health Assessment Questionnaire with your first order only. The questionnaire is included in your annual enrollment package, or it can be obtained by calling:
Merck-Medco Member Services
1-800-316-9178

c. a check or money order for an amount that covers your copayment for *each* prescription: $10 generic, $25 formulary brand-name, or $45 non-formulary brand-name. Checks or money orders should be made payable to *Merck-Medco Rx Services.* You can also have your copayment(s) charged to your credit card.

3. To order your mail service refill:

a. Send in your refill request at least three (3) weeks before your supply runs out. Requests for refills sent in earlier will be held at Merck-Medco Rx Services until the allowed refill date, and then dispensed and shipped to you.

b. For your convenience, you can order your refills, request renewals or order new prescriptions on-line at www.merckmedco.com.

Merck-Medco Rx Services will process your order and send your medication(s) to you by way of first-class mail (or UPS for controlled substances) along with instructions for reordering future prescriptions and/or refills, if any. Please allow up to fourteen (14) days for delivery of your medication(s).

To find out if your medication is on the Preferred Prescriptions Formulary, call Merck-Medco Member Services at 1-800-316-9178, or visit the Web site at www.merckmedco.com.

All prescriptions will be filled with an FDA-approved bioequivalent generic substitute if one exists, unless your physician specifies otherwise.

For information or if you have questions regarding the Mail Service Program, contact:

PERS Choice Health Plan
Merck-Medco Rx Services
P.O. Box 3939
Spokane, WA 99220-9870
1-800-316-9178

Partners For Healthy Aging Program

To meet the special needs of seniors, educational materials and counseling services are available to Plan Members aged 65 or older. As part of the Partners For Healthy Aging Program, Members receive a formulary “pocket guide” and a Patient Profile Health Assessment Questionnaire (HAQ), which have been designed specifically for seniors. Participation, although voluntary, is strongly encouraged.

The integration of information provided in the HAQ, along with medicine use information, allows for Member and provider counseling activities that are appropriately tailored to optimize an individual’s overall therapy. In addition, a newly revised Medication Guide Book for Seniors will be available.

For more information about this program, please call 1-800-316-9178.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Program:

1. Drugs or medicines obtainable without a physician's prescription, often called over-the-counter (OTC) drugs, except insulin and glucose test strips.

2. Contraceptives in the form of condoms, jellies, ointments, foams, patches, time-released subdermal drugs (e.g., Norplant implants), or devices.

3. Dietary and herbal supplements, minerals, health aids, and any vitamins whether available over the counter or by prescription, except Rocaltrol (Calcitriol), DHT and Hytakerol (Dihydrotachysterol) and Calderol (Calcifediol).

4. Anorexiants and appetite suppressants.

5. Anti-dandruff preparations.

6. Laxatives except as prescribed for diagnostic testing.

7. Supplemental fluorides.

8. Charges for the purchase of blood or blood plasma.

9. Hypodermic needles and syringes except as required for the administration of a covered drug.

10. Non-medical therapeutic devices or appliances, including support garments and other such items or appliances, regardless of their intended use.

11. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.

12. Drugs designed solely for or used to deter smoking.

13. Drugs labeled "Caution–limited by federal law to investigational use" or experimental drugs.

14. Any drugs prescribed solely for the treatment of an illness, injury or condition which is excluded under the Plan.

15. Any drugs or medications which are not legally available for sale within the continental United States or its territories.

16. Any charges for injectable immunization agents, allergy sera, or biological sera, including the administration thereof, whether provided by Medicare or not.

17. Any charges for the administration of prescription drugs or injectable insulin.

18. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a hospital or skilled nursing facility.

19. Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient hospital facilities, and services in the Member's home provided by Home Health Agencies.

20. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or medication furnished by any other drug or medical service for which no charge is made to the Plan Member.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

21. Any quantity of dispensed drugs or medicines that exceeds a thirty (30) day supply, unless prescribed for chronic conditions and obtained through the Mail Service Program. Mail service prescriptions are limited to a ninety (90) day supply of covered drugs or medicines as prescribed by a physician.

22. Refills of any prescription in excess of the number of refills specified by a physician.

23. Any drugs or medicines dispensed more than one (1) year following the date of the physician's prescription order.

24. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a non-Participating Pharmacy, or the mail service pharmacy.

NOTE: If Merck-Medco or its subsidiaries are the secondary carriers, the Coordination of Benefits provision does not apply.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

Services covered under this Supplement to Medicare Plan must be covered by Medicare. Except for vision care benefits, hearing aid services, and outpatient prescription drug benefits, any services or supplies that are not covered by Medicare are excluded under this Plan. (See also Vision Care Benefit Exclusions on page 13, Hearing Aid Benefit Exclusions on page 13, and Outpatient Prescription Drug Exclusions on pages 21 and 22.)

The title of each exclusion is not intended to be fully descriptive of the exclusion; rather, it is provided solely to assist the Plan Member to easily locate particular items of interest or concern. Remember that a particular condition may be affected by more than one exclusion.

Under no circumstances will this Plan be liable for payment of costs incurred by a Plan Member or dependent for treatment deemed by CalPERS or its Plan administrators to be experimental or investigational or otherwise not eligible for coverage.

General Exclusions

Benefits of this Plan are not provided for, or in connection with,* the following:

1. **Benefit Substitution/Flex Benefit/In Lieu Of.** Any program, treatment, service, or benefit cannot be substituted for another benefit or non-existing benefit. For example, receiving home health care benefits in lieu of an admission to a skilled nursing facility.

2. **Close-Relative Services.** Charges for services performed by a close relative or by a person who ordinarily resides in the Plan Member's home.

3. **Excess Charges.** Any expense incurred for services of a physician or other health care provider in excess of Plan benefits.

4. **Government-Provided Services.** Any services provided by a local, state or federal government agency, unless reimbursement by this Plan for such services is required by state or federal law.

5. **Non-Listed Benefits.** Services not specifically listed as benefits or not reasonably medically linked to or connected with listed benefits, whether or not prescribed by a physician or approved by Medicare.

6. **Voluntary Payment of Non-Obligated Charges.** Services for which the Plan Member is not legally obligated to pay, or services for which no charge is made to the Plan Member in the absence of health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

   a. It must be internationally known as being devoted mainly to medical research, and

   b. At least ten percent (10%) of its yearly budget must be spent on research not directly related to patient care, and

   c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and

   d. It must accept patients who are unable to pay, and

   e. Two-thirds of its patients must have conditions directly related to the hospital's research.

* The phrase "in connection with" means any medical condition associated with an excluded medical condition (i.e., an integral part of the excluded medical condition or derived from it).

7. **War.** Conditions caused by war, whether declared or undeclared.

8. **Workers' Compensation, Services Covered By.** Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of the injury or disease.

Medical Necessity Exclusion

The fact that a physician or other provider may prescribe, order, recommend, or approve a service, supply or hospitalization does not, in itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion or limitation. The Plan reserves the right to review all claims to determine if a service, supply, or hospitalization is medically necessary. The Plan may limit the benefits for those services, supplies or hospitalizations that are not medically necessary.

Limitations Due to Major Disaster or Epidemic

In the event of any major disaster or epidemic, Physician Members shall render or attempt to arrange for the provision of covered services insofar as practical, according to their best judgment, within the limitations of such facilities and personnel as are then available; but neither the Plan, Blue Cross nor Physician Members have any liability or obligation for delay or failure to provide any such services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.

CONTINUATION OF COVERAGE

Continuation of Group Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation of group coverage is provided through federal legislation and allows an enrolled active or retired employee or his or her enrolled family members who lose their regular group coverage because of certain qualifying events to elect continuation of coverage for eighteen (18) or thirty-six (36) months.

An eligible active or retired employee or his or her family member(s) is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the required premium is paid. The benefits of the continuation of coverage are identical to the group Plan and the cost of coverage may not exceed one hundred and two percent (102%) of the applicable group premium rate, except for the employee who is eligible to continue group coverage to twenty-nine (29) months because of entitlement to Social Security disability benefits, in which case, the cost of coverage for months nineteen (19) through twenty-nine (29) shall not exceed one hundred and fifty percent (150%) of the applicable group premium rate. No employer contribution is available to cover the premium.

Qualifying Events

Two qualifying events allow employees to request the continuation of coverage for eighteen (18) months: (This coverage may be continued for up to twenty-nine (29) months for federally recognized disabled employees.)

1. the covered employee's separation from employment (other than by reason of gross misconduct);

2. reduction in the covered employee's hours to less than half-time (or a permanent intermittent employee not working the required hours during a control period).

The following qualifying events allow enrolled family member(s) to elect the continuation of coverage for up to thirty-six (36) months:

1. the employee's or retiree's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS);

2. the divorce or legal separation of the covered employee or retiree from the employee's or retiree's spouse;

3. a dependent child ceases to be a dependent child due to marriage or attainment of age twenty-three (23).

Effective Date of the Continuation of Coverage

If elected, COBRA continuation of coverage is effective on the date coverage under the group Plan terminates.

Termination of Continuation of Group Coverage

The continuation of coverage will remain in effect for the specified period of time, or until any one of the following events terminates the coverage:

1. termination of all employer-provided group health plans; or
2. the enrollee fails to pay the required premiums on a timely basis; or
3. the enrollee first becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation after electing COBRA; or

4. the continuation of coverage was extended to twenty-nine (29) months and there has been a final determination that the enrollee is no longer disabled; or

5. the Plan Member is terminated from the Plan for cause.

Notification of a Qualifying Event

You will receive notice from your employer of your eligibility for COBRA continuation of coverage if your employment is terminated or your number of work hours is reduced.

The employee, retiree, or affected family member is responsible for requesting information about COBRA continuation of coverage in the event of divorce, legal separation or a dependent child's loss of eligibility.

Contact your employing agency or CalPERS directly if you need more information about your eligibility for COBRA continuation of coverage.

Individual Conversion Plan

Regardless of age, physical condition or employment status, you and your enrolled dependents may transfer to an individual conversion plan then being issued by Blue Cross when enrollment is terminated other than by voluntary cancellation or failure to continue enrollment or to make contributions while in a non-pay status. The individual conversion plan will also be available to a Plan Member whose continuation of group coverage expires under the group continuation plan.

However, if this Plan is replaced by your employer with another Plan, transfer to the Blue Cross conversion plan will not be permitted.

Applications for the conversion plan must be received by Blue Cross within thirty-one (31) days from the date coverage under PERS Choice is terminated.

To request an application, write to:

Blue Cross of California
P.O. Box 9153
Oxnard, CA 93031-9153

Benefits and rates of individual conversion plans will be different from those provided under PERS Choice and the premiums will usually be greater than PERS Choice's.

An individual conversion plan is also available to:

- Family members in the event of the Plan Member's death;
- Family members upon marrying or attaining age twenty-three (23) while enrolled under PERS Choice;
- Family members of an employee who enters military service; and
- The spouse of a Plan Member whose marriage has terminated.

When a family member reaches age twenty-three (23), or if a family member becomes ineligible for any other reason given above, it is your responsibility to inform Blue Cross. Upon receiving notification, Blue Cross will offer such family member an individual conversion plan.

CONTINUATION OF COVERAGE

Benefits After Termination

1. In the event the Plan is terminated by the CalPERS Board of Administration or by PERS Choice, PERS Choice shall provide an extension of benefits for a Plan Member who is totally disabled at the time of such termination, subject to the following provisions:

   a. For the purpose of this benefit, a Plan Member is considered totally disabled (1) when confined in a hospital or skilled nursing facility or confined pursuant to an alternative care arrangement; (2) when, as a result of accidental injury or disease, prevented from engaging in any occupation for compensation or profit or prevented from performing substantially all regular and customary activities usual for a person of the Plan Member's age and family status; or (3) when diagnosed as totally disabled by the Plan Member's physician and such diagnosis is accepted by PERS Choice.

   b. The services and benefits under this Plan shall be furnished solely in connection with the condition causing such total disability and for no other condition not reasonably related to the condition causing the total disability, illness or injury. Services and benefits of this Plan shall be provided only when written certification of the total disability and the cause thereof has been furnished to Blue Cross by the Plan Member's physician within thirty (30) days from the date the coverage is terminated. Proof of continuation of the total disability must be furnished by the Plan Member's physician not less frequently than at sixty (60) day intervals during the period that the termination services and benefits are available.

   Extension of coverage shall be provided for the shortest of the following periods:

   - Until the total disability ceases;
   - For a maximum period of twelve (12) months after the date of termination, subject to PERS Choice maximums; or
   - Until the Plan Member's enrollment under any replacement hospital or medical plan without limitation to the disabling condition.

2. If on the date a Plan Member's coverage terminates for reasons other than termination of the Plan by the CalPERS Board, by PERS Choice, or by voluntary cancellation, and the date of such termination of coverage occurs during the Plan Member's certified confinement in a hospital or skilled nursing facility or alternative care arrangement, the services and benefits of this Plan shall be furnished solely in connection with the conditions causing such confinement. Extension of coverage shall be provided for the shortest of the following periods:

   - For a maximum period of ninety-one (91) days after such termination; or
   - Until the Plan Member can be discharged from the hospital or skilled nursing facility as determined by PERS Choice; or
   - Until the Plan's maximum benefits are paid.

LIABILITIES

Third-Party Liability

If a Plan Member alleges that he or she has been injured through the act or omission of another person (a "third party"), PERS Choice shall, with respect to services required as a result of that injury, provide the benefits of the Plan only on the condition that the Plan Member:

1. Reimburses PERS Choice, to the extent of benefits provided, immediately upon collection of damages by him or her for such injury from any source, including any applicable automobile uninsured or underinsured motorist coverage, whether by action of law, settlement, or otherwise; and

2. Provides PERS Choice with a lien, to the extent of benefits provided by PERS Choice, upon the Plan Member's claim against or because of the third party. The lien may be filed with the third party, the third party's agent, the insurance company, or the court; and

3. Consents to the release of all information, medical or otherwise, which may be relevant to the identification of and collection from parties responsible for the Member's illness or injury.

If the Plan Member recovers from a third party the reasonable value of covered services rendered by a Preferred Provider, the Preferred Provider that rendered these services is not required to accept the amounts paid by PERS Choice as payment in full, but may collect from the Plan Member the difference, if any, between the amounts paid by PERS Choice and the amount billed by the Preferred Provider for these services.

Plan Member Liability When Payment is Made by PERS Choice

When covered services have been rendered by a Preferred Provider or Participating Pharmacy and payment has been made by PERS Choice, the Plan Member is responsible only for any applicable deductible and/or copayment. However, if covered services are provided by a non-Preferred Provider or non-Participating Pharmacy, the Plan Member is responsible for any amount PERS Choice does not pay.

When a benefit specifies a maximum payment and the Plan's maximum has been paid, the Plan Member is responsible for any charges above the benefit maximum, regardless of the provider's status who renders the services.

In the Event of Insolvency of PERS Choice

If PERS Choice should become insolvent and no payment, or partial payment, is made for covered services, the Plan Member is responsible for any charges incurred, regardless of the provider's status who renders the services. Providers may bill the Member directly and the Member will have no recourse against the California Public Employees' Retirement System, its officers, or employees for reimbursement of his or her expenses.

LIABILITIES

Plan Liability for Provider Services

In no instance shall the Plan or Blue Cross be liable for negligence, wrongful acts or omissions of any person, physician, hospital, or hospital employee providing services.

Maintenance of Preferred Provider Reimbursement Levels

If a Preferred Provider breaches or terminates its contract with Blue Cross of California for Preferred Provider services, PERS Choice may, based upon medical necessity, approve continuation of care at the Preferred Provider level of reimbursement. Upon PERS Choice's approval, reimbursement shall be made at the Preferred Provider level of reimbursement and the balance will be the obligation of the Plan Member.

In the event that a Preferred Provider is unwilling or unable to provide continuing care to a Plan Member, then it shall be the responsibility of the Plan Member to choose an alternative provider and to determine the Preferred Provider status of that provider.

COORDINATION OF BENEFITS

(Not Applicable to the Drug Program)

Coordination of Benefits is designed to provide maximum coverage for medical and hospital bills at the lowest cost by avoiding excessive payments.

This Coordination of Benefits section will apply only to Vision Care Benefits and Hearing Aid Services.

A questionnaire will be sent to you annually regarding other health care coverage or Medicare coverage. A questionnaire regarding third-party liability will be sent to you following Blue Cross' receipt of any claim which appears to be the liability or legal responsibility of a third party. Your cooperation in returning the form promptly will provide information necessary to process your claim. If another carrier has the primary responsibility for claims payment, please submit a copy of the Explanation of Benefits with the itemized bill from the provider of service. Your claim cannot be processed without this information.

A Plan Member covered under PERS Choice who is also covered under another group plan (or plans) will not be permitted to make a "profit" by collecting benefits in excess of actual value or cost during any calendar year. Instead, payments will be coordinated between the plans to provide payment by each plan up to each plan's Allowable Amount.

Definitions

Allowable Expense – A charge for services or supplies which is considered payable in whole or in part under at least one of the plans covering the Plan Member.

Other Plan – Any blanket or franchise insurance coverage, group service plan contracts, group practice or any other prepayment coverage on a group basis or any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans. The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Primary Carrier – A plan that has primary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions below.

Secondary Carrier – A plan that has secondary responsibility for the provision of benefits after the primary carrier determines its benefits according to the "Order of Benefit Determination" provisions below.

Order of Benefit Determination

When the other plan does not have a Coordination of Benefits provision, it will always provide its benefits first. Otherwise, the order of benefits is determined by the following rules:

1. A plan which covers the Plan Member other than as a dependent shall have primary responsibility for the provision of benefits before a plan which covers the Plan Member as a dependent.

2. When a plan covers the Plan Member as a dependent child whose parents are not separated or divorced, and each spouse is covered by a group plan which covers the Plan Member as a dependent, the plan of the spouse whose date of birth (excluding year of birth) occurs earlier in the calendar year shall have primary responsibility for the provision of benefits. If either plan does not have the provisions of this paragraph regarding dependents, primary responsibility for the provision of benefits shall be determined by the plan which does not include these provisions.

3. When a claim involves expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent will determine their respective benefits in the following order: first, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally, the plan(s) of the parent(s) without custody of the child.

4. Regardless of (3) above, if there is a court decree that otherwise establishes financial responsibility for the medical, dental, or other health-care expenses of the child, then the plan which covers the child as a dependent of that parent will determine its benefits before any other plan which covers the child as a dependent child.

5. If the above rules do not apply, the plan which has covered the Plan Member for the longer period of time will determine its benefits first, provided that:

    a. A plan covering a person as a laid-off or retired employee, or as a dependent of that person, shall determine its benefits after any other plan covering that person as an employee, other than a laid-off or retired employee, or such dependent; and

    b. If either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then paragraph (a) above shall not apply.

Effect on Benefits

If this Plan is the primary carrier with respect to a Plan Member, then this Plan will provide its benefits without any reduction because of benefits available from any other plan. Physician Members and other Preferred Providers may collect any difference between their Billed Charges and this Plan's payment from the secondary carrier(s).

If this Plan is the secondary carrier with respect to a Plan Member, and Blue Cross is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the benefits that would be due as if it were the primary plan, provided that the Plan Member (1) assigns to Blue Cross the right to receive benefits from the other plan to the extent of the difference between the value of the benefits which Blue Cross actually provides and the value of the benefits that Blue Cross would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Cross in obtaining payment of benefits from the other plan, and (3) allows Blue Cross to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

MEDICAL CLAIMS APPEAL PROCEDURE

The procedures outlined below are designed to ensure the Plan Member full and fair consideration of complaints submitted to the Plan. The procedures should be followed carefully and in the order listed.

Claims for payment must be submitted to Blue Cross within ninety (90) days after the date of the medical service, if reasonably possible, but in no event, except for the absence of legal capacity, may claims be submitted later than fifteen (15) months from the date of service or payment will be denied.

The following procedures shall be used to resolve any dispute which results from any act, error, or omission with respect to any **medical claim** filed by or on behalf of a Plan Member.

The cost of copying and mailing medical records required for Blue Cross to review its determination is the responsibility of the person or entity requesting the review.

Medicare Denied Claims

1. **Notice of Claim Denial**

   This Plan supplements the benefits paid by Medicare. If a medical claim has been denied by Medicare, the supplemental payment through this Plan will also be denied, as secondary payment by this Plan is dependent upon Medicare's primary payment. Blue Cross will notify the Plan Member of such denial in writing. The Blue Cross notice shall contain the reason for the denial.

2. **Claim Denial due to Medicare Denial**

   You may appeal the Medicare determination with Medicare if the Medicare claim is denied. Your appeal rights are detailed on the back of the Medicare Summary Notice form that is mailed to you. If, after the appeal process is completed, you receive notification from Medicare that the claim has been paid, this Plan will pay any covered supplemental benefits.

Claim Denials Under Your Vision Care Benefits or Hearing Aid Services

1. **Notice of Claim Denial**

   In the event any claim for benefits is denied, in whole or in part, Blue Cross shall notify the Plan Member of such denial in writing. The notice shall contain specific reasons for such denial and an explanation of the Plan's review and appeal procedure.

2. **Objection to Claim Processing or Denial**

   An aggrieved Plan Member may object by writing to Blue Cross' Customer Service Department within sixty (60) days of the discovery of any act, error, or omission with regard to a properly submitted claim; or within sixty (60) days of receipt of a notice of claim denial. The objection must set forth all reasons in support of the proposition that an act, error, or omission occurred.

3. **Time Limits for Response to Objection**

   Blue Cross will acknowledge receipt of a complaint by written notice to the Member within twenty (20) days. Blue Cross will then either affirm or resolve the denial within thirty (30) days. If the case involves an imminent threat to the Member's health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of the grievance will be expedited.

If Blue Cross affirms the denial or fails to respond within thirty (30) days after receiving the request for review and the Member still objects to an act, error, or omission as stated above, the Member may proceed to item 4 below.

4. Request for Reconsideration

If the Plan Member is not satisfied with the response to the initial inquiry, he or she may request reconsideration within sixty (60) days of receiving notice of Blue Cross' response. The request should be submitted in writing to the Customer Service Department. Any additional information that would affect the decision should be included. Blue Cross of California will acknowledge receipt of a reconsideration request by written notice to the Member within twenty (20) days. Blue Cross will then either affirm or resolve the denial within thirty (30) days.

5. Request for Administrative Review

If the Plan Member is not satisfied with the response to the Request for Reconsideration, he or she may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on page 35.

PRESCRIPTION DRUG APPEAL PROCEDURE

1. Denial of Payment for an Excluded Drug

When payment is denied because of a drug exclusion, the Plan Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on page 35.

2. Denial of a Drug Requiring Approval Through Prior Authorization

Appeals related to Prior Authorization requirements must be directed to:

Merck-Medco Managed Care, L.L.C.
700 West Third Avenue
Columbus, OH 43212
Attention: Managed Prior Authorization

If the plan Member is dissatisfied with the determination made by Merck-Medco, the Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on page 35.

3. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for prescription drugs are not payable when first submitted to Merck-Medco Managed Care, L.L.C. (see page 18). If Merck-Medco Managed Care, L.L.C., through its subsidiaries PAID Prescriptions, L.L.C., and Merck-Medco Rx Services, determines that a claim is not payable, a claim rejection letter will be mailed to the Plan Member explaining the reason(s) for nonpayment.

Appeals concerning direct reimbursement claims must be directed to:

PAID Prescriptions, L.L.C.
399 Jefferson Road
Parsippany, NJ 07054

If the plan Member is dissatisfied with the determination made by PAID Prescriptions, the Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure described on page 35.

Before rejecting a claim, Merck-Medco may, at its discretion, initiate its own review to determine if the claim can be paid. If the claim has erroneous or missing data that may be needed to properly process the claim, the Member may be asked to resubmit the claim.

If after resubmission the claim is determined to be payable in whole or in part, Merck-Medco will take whatever action necessary to pay the claim according to established procedure.

If the claim is still determined to be not payable in whole or in part after resubmission, Merck-Medco will inform the Plan Member in writing of the reason(s) for denial of the claim and will advise the Plan Member of his or her appeal rights as described in this section.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

If the Plan Member remains dissatisfied after the appeal procedures of the appropriate third-party administrator have been exhausted, the Member may appeal to CalPERS. This appeal must be submitted in writing to CalPERS within thirty (30) days from the postmark date of the administrator's final determination.

The appeal must be mailed to:

CalPERS Health Benefit Services Division
Appeals Coordinator — PERS Choice Health Plan
P.O. Box 942714
Sacramento, CA 94229-2714

The appeal must set forth the facts and the law upon which the appeal is based. The time limit may be extended an additional thirty (30) days if good cause is shown; however, in no event will an appeal be accepted more than sixty (60) days after the postmark date of the Plan's final administrative determination.

Examples of what may be appealed include, but are not limited to:
– Failure to properly pay incurred expenses.
– Denial of approval for covered services.

Examples of what *may not* be appealed include, but are not limited to:
– Medical malpractice.
– Reimbursement at levels specified in the Evidence of Coverage.

If CalPERS refuses to accept the appeal, the Member's option is to proceed directly to court.

If CalPERS accepts the appeal, the following procedures apply.

1. Administrative Review

The Plan Member may express his or her concern(s) by presenting information or arguments in writing to support his or her position. CalPERS staff will attempt to resolve or address the Member's concern(s) in writing within thirty (30) days from the date the Member presents his or her concern(s).

2. Administrative Hearing

If the dispute remains unresolved following the Administrative Review process, the matter will proceed through the administrative hearing process. These hearings are conducted in accordance with the Administrative Procedure Act (Government Code Section 11500 et seq.). Plan Members unrepresented by an attorney should become familiar with this law and its requirements if they choose to appeal to this level.

3. Procedures Before the CalPERS Board

After the administrative hearing, the Administrative Law Judge (ALJ) will issue a proposed decision which the CalPERS Board of Administration must adopt before it can take effect. The Board may either:

a. Adopt the ALJ's proposed decision; or
b. Reconsider the decision.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

4. **Appeal Beyond Administrative Process**
   Upon exhaustion of the appeal process outlined above, if a Member is still dissatisfied with the outcome, he or she may appeal to the courts.

Civil legal remedies may not be commenced until you have complied with these administrative procedures.

Summary of Process and Rights of Plan Members

- **Right to records, generally.** The Plan Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.

- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.

- **Right to an attorney.** At any stage of the appeal proceedings, the Plan Member has a right to be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney.

- **Right to experts and consultants.** At any stage of the proceedings, the Plan Member has a right to present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense.

Service of Legal Process

Legal process or service upon the Plan must be served at:

CalPERS Legal Office
Lincoln Plaza
400 "P" Street, Room 3340
Sacramento, CA 95814

MONTHLY RATES

Type of Enrollment	Enrollment Code	Cost
Insured Only	2231	$254
Insured and One Dependent	2232	$508
Insured and Two or More Dependents	2233	$762

State Employees and Annuitants. The rates shown above are effective February 1, 2001, and will be reduced by the amount the State of California contributes toward the cost of your health benefits plan. These contribution amounts are subject to change by legislative action. Any such change will be accomplished by the State Controller or affected retirement system without action on your part. For current contract information, contact the Health Benefits Officer at your employing agency or retirement system.

Public Agency Employees and Annuitants. The rates shown above are effective February 1, 2001, and will be reduced by the amount your public agency contributes toward the cost of your health benefits plan. This amount varies among public agencies. For assistance in calculating your net cost, contact the Health Benefits Officer at your agency or retirement system.

Rate Change. Plan rates may be changed on January 1, 2002, following at least sixty (60) days' written notice to the CalPERS Board of Administration before such change.

DEFINITIONS

Act – the Public Employees' Medical and Hospital Care Act (Part 5, Division 5, Title 2 of the Government Code of the State of California).

Administrator –

1. denotes CalPERS as the global administrator of the Plan through the Self-Funded Health Plans Unit of the Self-Funded Programs Division of CalPERS, also referred to as "the Plan"; and

2. denotes entities under contract with CalPERS to administer the Plan, also known as "third-party administrators" or "administrative service organizations."

Allowable Amount – the Blue Cross of California Allowance (as defined below) for the service(s) rendered, or the provider's Billed Charge, whichever is less. The Blue Cross of California Allowance is:

1. the amount Blue Cross of California has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based upon such factors as Blue Cross of California's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or

2. such other amount as the Preferred Provider and Blue Cross of California have agreed will be accepted as payment for the service(s) rendered; or

3. if an amount is not determined as described in either (1) or (2) above, the amount Blue Cross of California determines is appropriate considering the particular circumstances and the services rendered.

Annuitant – defined in accordance with the definition currently in effect in the Act and Regulations.

Appeal – refers to the Member's right to request review of decisions relating to the Member's rights under the Plan. The term includes all of the following: the internal review by Blue Cross and Merck-Medco Managed Care, L.L.C., sometimes referred to as a Plan grievance procedure; the Plan's final administrative review by CalPERS; the fair hearing accorded by statute; and any administrative and judicial review thereof.

Balance Billing – a request for payment by a provider to a Member for the difference between Blue Cross of California's Allowable Amount and the Billed Charges.

Billed Charges – the amount the provider actually charges for services provided to a Member.

Blue Cross – the claims administrator responsible for administering medical benefits under this Plan. As used in this booklet, the term "Blue Cross" shall be used to refer to both Blue Cross of California and BC Life & Health Insurance Company.

Board – the Board of Administration of the California Public Employees' Retirement System (CalPERS).

Close Relative – the spouse, child, brother, sister, or parent of a subscriber or family member.

Contract Period – the period of time from February 1, 2001, through December 31, 2001, during which benefits and benefit levels remain unchanged by the Plan.

DEFINITIONS

Custodial Care – care provided either in the home or in a facility primarily for the maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of illness or accidental injury. Custodial care includes, but is not limited to, help in walking, bathing, dressing, and feeding (including the use of some feeding tubes not requiring skilled supervision); preparation of special diets; and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Disability – an injury, an illness (including a nervous or mental disorder), or a condition (including pregnancy); however,

1. all injuries sustained in any one accident will be considered one disability;
2. all illnesses existing simultaneously which are due to the same or related causes will be considered one disability;
3. if any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous disability and not a separate disability.

Drugs and Medicines – those lawfully obtainable only on the prescription of a physician; the generic formulas which are approved by the Food and Drug Administration; but does not mean (1) appliances, devices, bandages, heat lamps, braces, splints, and artificial appliances; (2) health and beauty aids, cosmetics, and dietary supplements, except as specifically provided; or (3) such other drugs or items which are set forth as exclusions.

Employee – is defined in accordance with the definition currently in effect in the Act and Regulations.

Employer – is defined in accordance with the definition currently in effect in the Act and Regulations.

Experimental or Investigational – any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury, or condition at issue. Services which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered, shall be considered experimental or investigational. Services which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational. Any issue as to whether a protocol, procedure, practice, medical theory, or treatment is experimental or investigational will be resolved by Blue Cross, which will have full discretion to make such determination on behalf of the Plan and its participants.

Family Member – an employee's or annuitant's lawful spouse and any unmarried child under age twenty-three (23), including an adopted child, a stepchild, or recognized natural child who lives with the employee or annuitant in a regular parent-child relationship. It also includes an unmarried child under age twenty-three (23) who is economically dependent upon the employee or annuitant while there exists a parent-child relationship, or is dependent upon the employee or annuitant for medical support by reason of a court order. It also includes an unmarried child over age twenty-three (23) who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age twenty-three (23).

FDA – Food and Drug Administration.

Formulary – a listing of drugs in major therapeutic categories, selected by an independent committee of medical and pharmacy professionals who are either physicians or clinical pharmacists with a doctorate in pharmacology (Pharm D), and which are considered to be preferred over other drug alternatives. Formulary drugs are evaluated for: (1) indications; (2) side effects; (3) interaction with other drugs; (4) dosage form availability; (5) pharmacokinetics (how a drug is absorbed, distributed, metabolized and excreted); and (6) physician preference. The objective of the formulary is to improve the quality of patient care by promoting high quality, cost-effective prescribing and dispensing of prescription drugs.

DEFINITIONS

Health Professional – dentist; optometrist; podiatrist or chiropodist; clinical psychologist; chiropractor; clinical social worker; marriage, family and child counselor; physical therapist; speech pathologist; audiologist; licensed occupational therapist; physician assistant; registered nurse; a nurse practitioner and/or nurse midwife providing services within the scope of practice as defined by the appropriate clinical license and/or regulatory board.

Home Health Agencies and Visiting Nurse Associations – home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home and recognized as home health providers under Medicare.

Incentive Formulary Program — Members may receive any covered drug with copayment differentials between generic, formulary, and non-formulary drugs.

Incurred Charge – a charge shall be deemed "incurred" on the date the particular service or supply is provided or obtained.

Inpatient – an individual who has been admitted to a hospital as a registered acute bed patient (overnight) and who is receiving services that could not be provided on an outpatient basis, under the direction of a physician.

Medical Necessity/Medically Necessary – determined by the Plan for all services not covered by Medicare; determined by Medicare for services covered by Medicare.

Medicare – refers to the programs of medical care coverage set forth in Title XVIII of the federal Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Medicare Limiting Amount – refers to a federally mandated maximum amount a provider can charge a Member for covered services if the provider does not accept Medicare assignment. This amount cannot exceed fifteen percent (15%) more than Medicare's approved amount.

Member – See Plan Member.

Non-Participating Pharmacy – a pharmacy that is not under a valid agreement with PAID Prescriptions, L.L.C. to provide prescription drug services to PERS Choice Plan Members.

Non-Preferred Provider (Non-PPO) — a group of physicians, hospitals or other health professionals that (1) do not have a Prudent Buyer Plan Participating Provider Agreement in effect with Blue Cross of California at the time services are rendered, or (2) do not participate in a Blue Cross and/or Blue Shield plan network outside California at the time services are rendered. Any of the following types of providers may be non-PPO Providers: physicians, hospitals, ambulatory surgery centers, home health agencies or visiting nurse associations, facilities providing diagnostic imaging services, durable medical equipment providers, skilled nursing facilities, clinical laboratories, and home infusion therapy providers.

Open Enrollment Period – a period of time established by the CalPERS Board of Administration during which eligible employees and annuitants may enroll in a health benefits plan, add family members, or change their enrollment from one health benefits plan to another without any additional requirements.

PAID's Allowable Amount – the amount that a Participating Pharmacy and PAID Prescriptions, L.L.C., have agreed will be accepted as payment for the prescription dispensed.

Participating Pharmacy – a pharmacy that is under a valid agreement with PAID Prescriptions, L.L.C., to provide prescription drug services to PERS Choice Plan Members.

Pharmacy – a licensed establishment where prescription drugs are dispensed by a pharmacist licensed under the laws of the state where such pharmacist practices.

DEFINITIONS

Physician – a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Physician Member – a licensed physician who has contracted with Blue Cross of California to furnish services and to accept Blue Cross of California's payment, plus applicable deductibles and copayments, as payment in full for covered services.

Plan – means PERS Choice Supplement to Medicare Plan. PERS Choice is a self-funded health plan established and administered by CalPERS (the plan administrator and insurer) through contracts with third-party administrators: Blue Cross and Merck-Medco Managed Care, L.L.C. (a.k.a. PAID Prescriptions, L.L.C., or Merck-Medco Rx Services).

Plan Member – any employee, annuitant, or family member enrolled in the PERS Choice Supplement to Medicare Plan.

Plan Year — an eleven (11) month period starting February 1, 2001 at 12:01 a.m. Pacific Standard Time and ending at 12 midnight PST on December 31, 2001.

Preferred Provider (PPO) – a group of physicians, hospitals or other health professionals that (1) have a Prudent Buyer Plan Participating Provider Agreement in effect with Blue Cross of California at the time services are rendered, or (2) participate in a Blue Cross and/or Blue Shield plan network outside California at the time services are rendered. Any of the following types of providers may be PPO Providers: physicians, hospitals, ambulatory surgery centers, home health agencies or visiting nurse associations, facilities providing diagnostic imaging services, durable medical equipment providers, skilled nursing facilities, clinical laboratories and home infusion therapy providers.

Prescription Drugs – all drugs which under federal or state law require the written prescription of a physician, dentist, podiatrist, or osteopath; insulin; hypodermic needles and syringes if prescribed by a physician for use with a covered drug; glucose test strips; and such other drugs and items, if any, not set forth as an exclusion.

Prescription Legend Drug – any medicinal substance, the label of which is required, under the Federal Food, Drug and Cosmetic Act, to bear the legend "Caution: Federal laws prohibit dispensing without a prescription."

Prescription Order – the request for each separate drug or medication by a physician and each authorized refill of such request.

Regulations – the Public Employees' Medical and Hospital Care Act Regulations as adopted by the CalPERS Board of Administration and set forth in Subchapter 3, Chapter 2, Division 1, Title 2 of the California Code of Regulations.

Services – medically necessary health care services and medically necessary supplies furnished incident to those services.

Subscriber – the person enrolled who is responsible for payment of premiums to PERS Choice, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan.

Total Disability –

1. with respect to an employee or person otherwise eligible for coverage as an employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage.

2. with respect to an annuitant or a family member, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage.

United States – all the states, District of Columbia, Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

FOR YOUR INFORMATION

Organ Donation

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

Long-Term Care Program

Your PERS Choice health plan has strict limits on the long-term care services it provides. The Long-Term Care Program offered by CalPERS provides coverage for the extended care you could need due to a chronic disease, frailty of old age, or serious accident. It covers help with activities of daily living, such as bathing eating and dressing. It also provides supervision and support for people with cognitive impairments such as Alzheimer's disease. Long-term care can be needed at any age.

The CalPERS Long-Term Care Program is not part of the PERS Choice health plan. If you want long-term care protection, you must purchase it separately. Please contact the CalPERS Long-Term Care Program at 1-800-338-2244 if you are interested in long-term care coverage.

Supervised by:

Self-Funded Programs Division
California Public Employees' Retirement System

PER-0201-SP2